Losing the Battle
The Challenge of Military Suicide

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JOHN NAGL: Good afternoon, ladies and gentlemen. Thanks for being here. My name is John Nagl. On behalf of all of us here at the Center for a New American Security, I'd like to welcome you to this discussion on the important, challenging, and very, very right now question of military suicide.

Our nation has now been engaged in war for more than a decade, the longest period of continuous combat in our history. The all-volunteer force has performed magnificently, but is showing signs of strain, including troublingly a steady increase in the number of service members who are falling by their own hand. The problem is urgent.

A good friend of mine currently serving as a brigade commander has lost five soldiers to suicide just this calendar year. This problem demands everything we can do to solve it. Those who volunteer to serve us deserve our support when they themselves are suffering.

Dr. Meg Harrell, CNAS Senior Fellow and director our Joining Forces Initiative has written a policy brief titled "Losing the Battle: The Challenge of Military Suicide." "Losing the Battle" examines this crisis dispassionately and suggests a number of solutions that may help diminish this horrific loss of our most precious national resource: the lives of our sons and daughters who have chosen to serve their country.

To discuss this issue with Meg, we are honored to have back with us General Peter Chiarelli, vice chief of staff of the United States Army. No one has worked harder or done more to solve this problem. No one has done more. Thank you, sir. (Applause.)

We also welcome Dr. Jan Kemp, National Mental Health Program director for the Department of Veterans Affairs which has an important role to play in helping those who continue to carry the scars of their service after they have taken off the uniform.

The panel will be moderated by Juliette Kayyem, national security columnist for the Boston Globe, and a lecturer in public policy at Harvard University.

From its founding, CNAS has focused on the health of the force as an important component of our national security. The reasons soldiers fall by their own hands are many and complex, and they reinforce each other in ways that are hard to understand. Solutions are also complex. No one agency or organization can do everything that is necessary to solve this problem, but many can help.

We're honored to have the support of a number of philanthropic partners listed at the end of "Losing the Battle" who share our concern about the health, employment prospects and education of those who have sacrificed to serve us. Our partners have joined forces with us to think about this public – this pressing public health issue and to attempt to find solutions.

Thanks to them, thanks to all of you here, and to all of those joining us nationwide via webcast for being a part of this important discussion.

And, Juliette, the floor is yours.

JULIETTE KAYYEM: Thank you very much. It is an honor to be here, and I want to thank CNAS, Meg, Nancy Berglass, who's the coauthor but not here with us today, and the whole community for their efforts in exploring the issue of suicide among our service members and veterans.

I have been in government and recently left as assistant secretary of the Department of Homeland Security, and returned to Boston where I do write a twice a week column for the Globe. And it was starting to write about the wars and how they were ending that this issue began to interest me and did seem to have enough national focus as it should warrant.

For someone like me not familiar with these issues, my several month exploration with the help of Dr. Harrell and CNAS into how this nation will address the end of wars and the impact they have had on our military is surely going to be a critical challenge for not just our military, but the United States government, our political leaders and our citizens in the decades to come. The wars may be ending in some respects, but they are not over.

The report, which I have had an opportunity to read, is a straightforward examination of what can and should be done to address one persistent and troubling problem: suicide. As the report notes, from 2005 to 2010, service members took their own lives at a rate of approximately one every 36 hours. The VA estimates that a veteran dies by suicide every 80 minutes. We'll talk about drilling down on those numbers.

Now, these numbers are complicated. The Army is in a different position than the Air Force or the Navy or the Coast Guard. Veterans' data is difficult to manage and understand given challenges with data collection. But as you read and examine the report and listen,

there are two important takeaways I believe for those of us who are grappling with the policy and, of course, for many of you, the personal consequences of this issue.

First if the how, how can we best adopt policies – and, indeed, some of the recommendations are in here – at a time when resources are scarce, Congress is divided, and much of our political focus is, of course, on the economy.

And then the second is the "why." I know this sounds obvious given the issue we're talking about, but an important aspect of this report is in making clear why we need, as a government and as people, to get this right. It is, of course, about our present service members and our veterans. But as the report and Dr. Harrell and Nancy Berglass also make clear, it is also about the future of our military, an all-volunteer military.

So I want to begin with setting the stage for the report and the findings in the report with the co-author, Dr. Harrell.

MARGARET HARRELL: Thank you. Thank you to everyone for joining us today, both here in this room and also online. Thank you especially to my co-panel members for bringing your tremendous expertise to today's discussion.

One challenge of the topic of suicide is that research is unable to quantify fully the number of lives that are saved by the tremendous efforts of individuals such as General Chiarelli and Dr. Jan Kemp, who devote considerable energy to understanding and improving the resources available for our service members and veterans.

Today's panel is the first event of our Joining Forces Initiative at CNAS. As an independent partner to the White House's Joining Forces Initiative, CNAS has determined our Joining Forces research agenda to include research and analysis in three areas: employment, education, and wellness as those areas pertaining to veterans, service members and to military families.

This work on military suicide was conducted in the context of our wellness research. I have been asked whether for the first CNAS Joining Forces product and event we should have led with a different topic rather than military suicide. After all, it's only a very small minority of service members and veterans that die by suicide. We feel, however, that it is too large a

minority and too significant an issue to ignore given that these tragic losses affect many individuals besides those victims.

The Army brigade commander that Dr. Nagl mentioned recently brought his command team to CNAS for a discussion. Our conference room was overflowing with his officers who only wanted to discuss military suicide with me because they deal with this every day, because it's happening now, and because changes can occur now.

Further, the importance and urgency of this issue pertain to more than the service members and veterans who tragically die by suicide and their families. Military suicide is a national security issue. George Washington said, "The willingness with which our young people are likely to serve in any war, not matter how justified, shall be directly proportional to how they perceive the veterans of earlier wars were treated and appreciated by their nation."

If Washington was correct, suicide among service members and veterans threatens the health of the all-volunteer force. Mentors and role models, including parents, teachers and, importantly, veterans play a critical role in the enlistment decisions of young men and women. We should realize that these mentors and role models will not steer youth toward the military if they perceive damage to service members or a failure to address the mental health care needs of those who have served their country.

Our policy brief acknowledges that eliminating suicide amongst service members and veterans is an unreasonable goal. However, there are some obstacles to addressing suicide that should be resolved. Some of these obstacles can be addressed within the military services while others cannot. Some of these obstacles are especially difficult to eliminate.

At CNAS we felt urgency to host this session and to release our policy brief because we believe that we have actionable recommendations that can help address this issue.

There are actions the services can take internally, such as continuing to address the stigma of mental health care, establishing a post-deployment unit cohesion period, encouraging service members to answer their post-deployment health assessment questions truthfully, and coordinating legal investigators with unit commanders to ensure the safety of service members. Some of these actions are being taken in some of the services and with some success.

There are also measures that can be taken specifically for the Guard and Reserve to include establishing communication plans so that unit leaders have interaction with their troops between drill weekends, and developing a system wide suicide prevention program for the Guard that does not depend upon dwindling state resources.

We also have recommendations that cannot be addressed solely within the military services. DOD military treatment facilities need the authority to conduct take back programs of excess prescription medication. Military leaders need to be able to discuss personally owned weapons with their troops, and military service members and family members need to be able to maintain a relationship with the mental health care provider that they have invested in, even if their service moves them to a distant installation.

Finally, we need to understand how many veterans die by suicide and who these veterans are. That will require the coordination and cooperation of the Department of Defense, the Department of Veterans Affairs, and the Department of Health and Human Services.

We know that the number of active duty suicides nearly doubled over the last 10 years, from 160 in 2001 to 295 in 2010. By VA estimates, every day equates the loss of another 18 veterans by suicide. This is happening now and we need to address this now.

MS. KAYYEM: Thank you. Thank you, Dr. Harrell. I'm going to turn next to General Chiarelli and first thank him for his tremendous work. If you just begin to explore this issue, the work you've done has saved lives, as Meg has said. I wanted to know if you could begin with providing a context for the understanding of both the problem and the solutions and the work that's being done to address this problem immediately.

GENERAL PETER CHIARELLI: Well, thank you very much and good afternoon. I appreciate the opportunity to participate in this important discussion.

I must correct those numbers. We had 162 active component soldiers commit suicide in 2010, 162 active component. That's of a force of 700,000. Two hundred and ninety-five is the total number of suicides of the entire force, 1.1 million to include Guard and Reservists.

As many of you know, for the last two and a half years I have served as the Army's lead for integration of the ongoing efforts to reduce the incidence of suicide across our force. Back

in January of 2009, then Secretary of the Army Pete Geren and General John Casey tasked me with lowering the rate of suicides.

And I approached it like I did every other challenge going back to my days as commander at just about every level. I'm an operator and I approached it like an operator. They wanted me to lower the rate of suicide; I was going to lower the rate of suicides. I quickly learned it wasn't that simple. In fact, the challenge of suicide has proven to be the most difficult in my 40 years in the military.

That said, if there's one thing – and I'm going to push back a little bit, because that's what you would expect me to do, wouldn't you – if there's one thing in particular I would take offense to with respect to this report is the implication that we have done little and certainly not enough to address this issue. This could not be further from the truth. And I do not believe we are losing the battle, as the headline states. To the contrary, I believe we've made tremendous progress in understanding these very, very complex issues and making sure that leaders and soldiers understand them.

I sit through a senior review group meeting which is once a month for two hours. We review every single suicide in the Army. Bonnie Carroll is normally with me every single month to go through them. We have unit level commanders, members of the medical community, all together in discussion. And I contest after doing this for two years the circumstances surrounding each suicide are as unique as the individuals themselves. That's what makes this issue so incredibly tough to influence one way or the other.

That said, we greatly expanded the resources and support services available, and we're working hard to eliminate the longstanding stigma associated with behavioral health conditions. And that's just not a military problem. That's all our problem, the stigma associated with mental conditions. Funding programs in services and instituting them Army wide – that's the easy part. The really hard part is eliminating the longstanding stigma, breaking down the invisible barrier that is prevalent in society as it is in the military. And the key to doing so is raising awareness.

We take a step back in my opinion in what already is a very difficult, very difficult endeavor when someone writes or speaks about this topic in an overly alarmist way or without accurately conveying all the facts, both in the terms of the complexity of the challenges and the efforts underway to address it effectively.

One of the most important lessons we learned early on in the process is that suicide is a symptom, albeit the extreme of a much, much bigger problem.

I've got this sphere chart up here, up at the top, that shows you kind – tries to put this problem in perspective. We can really only gather good data on active component soldiers. And although there are 570,000 in the active component, that big blue ball represents about 700 to 750 because we have soldiers who are mobilized, which expand our force. That's really where I can only gather the best data because I send a medical examiner out every single time that applies the same standards to every death to make a determination of death.

And as you can see there, as you follow this down, you see the different kinds of high-risk behavior. And, finally, you see the little dot that we've had to go ahead and shade that shows the number of suicides in comparison to that big blue ball. Finding in that big blue ball of 225 to 50,000, depending on the year, the 250 that will commit suicide is the most difficult task. And that is why we have focused on trying to identify the high-risk behavior.

Soldiers on active duty, the red sphere, represents soldiers receiving behavioral health care. That's good news. The green sphere represents those soldiers currently on prescription medication. Again, in many instances that is good news. However, as you continue to the right, you get further and further into the risky and high-risk behavior. And the most extreme cases, of course, are suicides.

These challenges are further complicated in many cases by the physical injuries to the brain. You simply cannot have a fruitful discussion about the issue of suicide without acknowledging the immaturity of brain science, pure and simple. Every scientist, researcher and doctor you'll ask will agree. We simply do not know enough about the brain. Yet, the most common injuries of this war are not amputations or burns, as you might think.

The signature wounds of this war are actually post-traumatic stress and traumatic brain injury. And they have been of every war. I don't know how many of you saw the HBO documentary "Wartorn: 1861-2010," where they talked about in every war. We've only changed the name of what post-traumatic stress is.

In order to reduce the incidence of risk and high-risk behavior, including suicide across our force, we must continue to find ways to reduce stress, promote health, build resiliency, and

eliminate the longstanding stigma associated with seeking and receiving health. In other words, we must focus on the area indicated by the red sphere and address these issues and challenges as early as possible.

To answer your question, what are we doing to address the issue of suicide, over the past two and a half years since the establishment of the Health Promotion Risk Reduction and Suicide Prevention Task Force and Council in March of 2009, and the subsequent publication of our report in 2010, often referred to as the "Red Book," we've instituted a number of very effective program and policy changes across our force.

These include: increased access to behavioral health care to include telehealth options as well as confidential counseling programs; stigma reduction campaign efforts; mental fitness and resiliency training programs; expanded family support programs; expanded substance abuse surveillance. This list merely skims the surface. And the programs and initiatives are having an impact. We believe we are in fact making progress.

Now, I expect many of you will respond, well, then, why haven't your numbers gone down? The reality is it is impossible to prove a negative. And when you look at active duty suicides last year in the Army, they went down by six. The reality is it's impossible, as I said, to prove that negative. I can tell you how many did tragically make the decision to take their own lives in this past year, but I cannot tell you how many contemplated suicide yet, as a result of our collective efforts did not end up going through with it. The fact is that behavioral health encounters increased 12 percent in fiscal year 2010. Virtual behavioral health care encounters primarily benefiting soldiers located in remote locations or apart from insulations have also increased significantly and that is very, very encouraging.

Now, I'll be the first to admit there's still much work to be done. Any suicide or high-risk death is one too many. This is an enduring challenge that requires an enduring commitment and we must continue our efforts. We owe it to our men and women in uniform, and their families, to ensure they have access to the very best care, treatment and support while serving on active duty, as a member of our Reserve component, and also after they've separated or retired from military service. The Army is continuing to work closely with our sister services and with DOD and the Department of Veterans Affairs toward this shared endeavor.

I'll close my opening comments by simply stating for the record I am incredibly proud of all we've accomplished to date to reduce the stress on the force, reduce the incidence of risky and high-risk behavior, reduce stigma for health seeking behavior and ensure that soldiers and families in need have access to the appropriate care and are able and willing to take advantage of it.

Thank you again for the opportunity to participate in this event. And I look forward to a great discussion.

MS. KAYYEM: Thank you, General Chiarelli. I wanted to – before we run on to Dr. Kemp, I think it's just worth for everyone watching and listening on the webinar, let's just talk about the numbers. So I'm going to go out of order here.

Dr. Harrell, where are we on the numbers? Why is there a disagreement, so maybe just – even if we're talking about a different set, at least everyone is on the same page.

MS. HARRELL: It's a great question because the numbers are tricky. And so the number of that I cited is the active duty number. That includes active component personnel but it also includes Guard and Reserve personnel that were activated at the time.

GEN. CHIARELLI: What number is that?

MS. HARRELL: The 295.

GEN. CHIARELLI: That's not the correct number.

MS. HARRELL: Okay. Let me speak to that for a moment because it matters literally what day of the week a Reserve or Guardsman dies by suicide. That affects which number he's counted as. The numbers also shift as investigations occur and past events are resolved into suicide or not suicide events. The numbers change a lot. It's important to assess that. I think we agree in many ways. I think one way that I do disagree is I think we're losing the battle multiple times a day right now.

GEN. CHIARELLI: I just have to correct those numbers. The total number of activated plus active component soldiers is somewhere between 725 and 750 a year, I promise you.

That number last year was 156; the year before it was 162. We had a decrease of six active component suicides last year, which included mobilized Reserve component soldiers.

It's important you understand those statistics because in those instance, when a soldier is activated, I send a medical examiner out for every single death. That medical examiner applies the same standards to that death in determining whether that death was accidental or suicide. That's why we parse the numbers that way. That is a total between 725 and 720 depending on the year. We had a huge increase last year in suicides of soldiers who were not on active duty. And that's the 295 number when you include that number in with those who are on active duty.

The problem with that number is it's probably underestimated because every single community investigates and applies different standards to death. And we all know the pressure that is sometimes put on medical examiners not to categorize a specific death as suicide.

So I think the numbers that I have the most confidence in are those numbers of folks who are on active duty, both the National Guard, Reserve and active component soldiers when they die because we're able to apply the same standards in making a determination. I'm not saying the standards are right, but they're the same every single time because that's how we investigate those deaths.

MS. HARRELL: So those – are those numbers for the Army only?

GEN. CHIARELLI: That's the Army only.

MS. HARRELL: Okay. My numbers were total.

MS. KAYYEM: We haven't even gotten to veterans yet. So the numbers – the numbers issue gets more complicated. I think just for everyone's – everyone is sort of on the same page, the numbers are going to be different depending on if you look at active units, which is now 156, and your number is –

MS. HARRELL: Two hundred and ninety-five all services.

MS. KAYYEM: Two hundred and ninety-five all services. In every event, everyone here at this table agrees a problem that's too big for anyone's purposes. And we have not gotten to the veterans.

So I want to turn to Dr. Kemp to discuss – Dr. Kemp, when I read the report and the work that's being done with the veterans, of course a primary issue is what number are we talking about? And then, if you could talk a little bit about how are you approaching this systemically given what we're about to encounter both with the Iraq and Afghan veterans.

JAN KEMP: Yes. I'm actually going to make the numbers debate a little easier and tell you I have no idea –

MS. KAYYEM: Okay. (Laughter.)

MS. KEMP: – actually how many veterans a day die by suicide. And it's silly to think that we do at this point. I think if you read the report, you'll certainly understand Meg's plea and recommendations that we need to solve the numbers problem.

And we're making huge strides in the VA with our DOD and our CDC partners to do that, but it's not happening quickly. Secretary Shinseki has taken on this goal himself, has brought in the support of the governors of our states. We're now getting data on a more timely basis that talks about veteran suicide. We're able to put that together and come up with some estimates which you've seen, and you've seen the estimated numbers of 18 veterans a day dying by suicide. Honestly, I don't know how correct we are in that. It's our best guess right now.

I also want to address the title of the report a little bit. I think as long as any veteran or service member dies by suicide we are in fact losing the battle. But I do maintain that we've made huge strides towards winning the war over the past several years. And we will continue to do that. The VA has taken the stance that suicide prevention is based on ready access to high-quality mental health care. And to that end we've instituted a whole series of programs that I won't go into now but certainly I'm available to talk to any of you about it anytime.

Probably the most visible access mechanism that we've instituted in the past four years is the Veterans Crisis Line which now has taken over 450,000 calls into the line from veterans,

families and service members. The fact that we continue to take those calls – and I have to tell you, when I was first approached about opening the crisis line, I said, you know, I don't think veterans will call. I think we have crisis lines in the country. Why don't we use those? I'll help facilitate those connections. And I was told, Jan, why don't you start a crisis line? I said, okay, I'll be glad to do that. And I have never been so wrong about anything in my entire life. Veterans do call, all genders, all ages, people with all sorts of needs. If the services are there and help is there, people are reaching out to get them. And so our task has become being available.

What you all know is a slightly different take on VA services. And it's working for us in all sorts of ways and shapes that we didn't imagine, and we'll continue with that effort.

Getting people into services is a major issue. Providing those services once we have them is another major issue. And we too have expanded programs. We've opened telemental health programs. We've increased mental health services at community-based clinics.

But you're all sitting there looking at me and saying, it's not enough. And we know that. And we'll continue to find out where we need to put more services and more time and more energy and we will continue to grow those programs and to offer people what they need. And that's a promise we're making.

MS. KAYYEM: Dr. Kemp, I wanted to – on the numbers because I think this is just a key part of the recommendations as well but the key part of the report. Can – no, no, no. I wanted to say, can you explain to the audience why is it so hard for the VA, because I don't know if people understand why that part of the numbers is difficult for the VA?

MS. KEMP: Yes. If someone is active duty and they don't show up for work the next day or they're missing out of their unit, they're obviously gone and someone looks for them and finds them and finds out what happens to them and knows that they died. Veterans have no obligation to check in anywhere at any given point in time ever about anything. And so if – (laughter) – and neither do I. So we don't have the luxury, I should say, of knowing when someone chooses to take their own life when they choose to do that.

So we need to rely on – for veterans who get care in the VA, which is not everyone by any means, that them not showing up for an appointment, which may or may not be scheduled. If you or I don't go to our doctor's appointments, very seldom does someone call and find

out where I am or why I didn't come. But we have instituted programs in the VA to do those follow-up calls and find people.

If they don't get care in the VA, we don't know that they've died. So we rely on the state death certificate data to provide us with that information. Not all states collect or report veteran status to the Center for Disease Control, which is the overarching group that maintains death numbers in the United States. There's a small percentage of states – 17 right now, to be exact, that report these numbers on a regular basis. So we've had to take those numbers and draw conclusions from that. There's a huge time delay. Right now we're working with the CDC to get the 2009 data. So it's not available yet.

GEN. CHIARELLI: For the economic downturn.

MS. KEMP: Right.

GEN. CHIARELLI: We don't have any data to compare civilian suicides after the economic downturn because CDC hasn't published it.

MS. KEMP: So it's a struggle to figure out even if we're making an impact with the programs that we've implemented.

MS. KAYYEM: General Chiarelli, I wanted to follow up on the important point you made, on the review of each suicide, every suicide is a different story. If you could though make one sort of systemic recommendation for at least the Army, either it's an obstacle that should be removed or something that should be done, looking at these sort of across – what do you think that would be?

GEN. CHIARELLI: The number one systemic recommendation I would make is the study of the brain. I promise you if there's anything we need to do, that's what we need to understand, and we just don't understand enough. Now, please don't take what I'm going to say as saying we don't want people to seek help from behavioral health specialists. We do. We want them to seek help.

But in studying those suicides over every single suicide, 50 percent of the soldiers who commit suicide in the United States Army had behavioral health care. It's 50/50, almost a complete wash. They're seeing somebody or have seen somebody, sometimes numerous

times, sometimes in – and Bonnie will attest to this. We sit and listen to cases where they were seeing a behavioral health specialist who indicated they were a low-risk case and within 24 hours they were found dead. I mean, that is what is so perplexing about this.

And until we understand more about how the brain works, until we understand the effects of post-traumatic stress – I mean, one number that I've seen out there is that if you have post-traumatic stress, you are six times more likely to commit suicide than if you don't have post-traumatic stress. If you have post-traumatic stress, you are six times more likely to participate in partner aggression, which is a nice term for something else. I mean, we just don't know. And if anything, we need to continue the research.

Now, we think we're close to having a biomarker for concussion, which will be huge. There are no biomarkers for the brain right now. I mean, the scary part for me at my age is going to the doctor's, not the examination. It's when the blood work comes back. You just hope the guy has a smile on his face because he can tell from that blood work just about everything about you except how your brain is doing.

And we think we are very, very close to having a biomarker where we're going to be able to, when a soldier is in some kind of an event which we think is a concussive event, we can go up to him, we can prick their finger, not unlike you would do for a diabetic to check blood sugar, and we will be able to tell whether or not that individual has had a concussion.

Now, why am I talking about concussions? Because the co-morbidity between the symptoms between post-traumatic stress and traumatic brain injury are like this – co-morbidity to doctors means they share the same symptoms. And part of the problem is trying to diagnose those folks when they come back who the ones that produce themselves and indicate they have a problem as opposed to those who try to hide it because they're type A people who just because of the stigma attached to this just don't want to tell anybody.

MS. KAYYEM: Okay. I'm getting the queue for Q&A which I'd like to begin and delve into the recommendations. A couple of things on the Q&A. We know this is obviously an emotional issue for many people and want to respect that but also to utilize this forum, this open forum for a discussion about some of the recommendations and some things that can be done by the government, by citizens, by local and state governments about this. So I wanted to, if you could, announce who you are and ask a question. If it's for the whole panel, let me know. If it's for one particular person, let them know.

Q: Thank you. One of the myths about suicides in the military is that it's somehow tied or related to the quality of the volunteers who have signed up over the last 10 years and related in particular to recruiting decisions made during the mid-point of the Iraq war. It's not mentioned in the report, Meg.

And General Chiarelli, you probably have the best data on this. If you could speak to that and tell us whether there's any relationship between fitness measures, recruiting measures, et cetera, and the folks committing suicide.

GEN. CHIARELLI: We found none whatsoever. I mean, one of the most difficult things for us to do is to do the evaluation because HIPAA kicks in here, as the report properly points out. There are all kinds of HIPAA issues that are involved with screening of the recruits who may in fact have behavioral health issues. And as many as – as SRG briefings go, we see many, many times that an individual who commits suicide had mental health problems prior to joining the service and that only becomes visible to us after they commit suicide because we can't get at those records. But we have seen nothing in data that would show that there's anything to do with waivers or anything else that leads toward higher incidence of suicide.

I think that when you look at our numbers, when the CDC corrected numbers and, again, I totally agree. We don't have numbers for 2009. Our latest numbers are 2008. When we collect that population for the population we have in the service, in civilian life it's 19 per 100,000, just over 19 per 100,000 commit suicide. In the military, in the Army, last year it was 22 per 100,000, an increase of three. That is three – that is 22 too many.

And no way do we not want to attack this problem, but the issue for me is trying to understand it. It is so much more complicate than I thought it was when I set out to solve it.

I mean, one statistic that I can tell you right off the bat is in the cases that I look at, 72 percent of those cases is an individual who's got a relationship problem; 72 percent of the cases in the United States Army last year had a relationship problem. And you say, aha, that's the reason. Anybody who has a relationship problem goes into a higher risk category. Well, that's not necessarily the case because what you see with post-traumatic stress is relationship problems are the result of all the other things that happen from alcohol abuse to drug abuse, to problems getting along with your partner – you name it. And finally it

ends in a relationship issue. That relationship issue could be the culmination, the straw that broke the camel's back. I don't know. But that's what makes this so difficult. But I won't say that relationships cause suicide.

MS. KAYYEM: If other panelists want to add anything, just let me know, but we'll go to – otherwise we'll go to – right there.

Q: Hi. My name is Kristy Kaufmann. I'm a 10-year Army wife and the executive director of Code of Support Foundation. As such, I really appreciate this in-depth conversation. And General Chiarelli and I have spoken in depth about some of these issues.

I think one of my concerns is when you have the title of a report dealing with military suicides and no one's mentioned the suicides we're seeing among the family members. I know that there are tracking challenges to this. And General Chiarelli and I have talked about them, but if you're going to start really trying to track the veteran population and if you look at the collaborative efforts that you mentioned with DOD, VA, and Health and Human Services, unless we can get some numbers behind this, I can stand up to these conferences and I always say the same thing: I've lost three Army wife friends to suicide. But I can tell you that anecdotally, and if we don't have the numbers, it's very difficult to develop any kind of traction behind it.

Based on some of the recommendations that you made, I would say that the federal exemption of state licensing is a huge one. It's been a big problem for us within a community when you build a relationship with a therapist and then having to leave that therapist. DOD had something called In Transition. I'm not sure it still exists, but it was a program that tried to deal with that, that did not apply to the family members. That's kind of the issue is that when we talk about these suicides or suicide prevention or just mental health in general, we have to be better at looking at holistically and integrating the families into it.

I think that there are SOPs that are missing, and General Chiarelli and I have talked about this, when a solider commits suicide, they have a DOD suicide event report. There's really no SOPs in place or policies dealing with what happens when the family member attempts or commits suicide. And unless we have that data, again, it's going to be difficult to get to some of the issues.

Finally, I just wanted to say, even if everything that DOD will be working perfectly, and we know it's not, we simply do not have the resources in house to take care of the need after 10 years of war, so there are internal changes that we need to make to – whether it's a joint ethics law or regulations or interpretations thereof, and then there are external challenges that we all on the 501(c)3 need to be more effective in integrating our services into that community. Thank you.

MS. KAYYEM: Thank you so much. Meg, do you want to respond?

MS. HARRELL: Just that I think you're absolutely right. I think there are lots of data challenges. And the need to know more about not just service members, veterans, whether affiliated or unaffiliated, I think we need to know more about military families and families of veterans.

MS. KAYYEM: Is that tracked at all, the military families through the veterans?

GEN. CHIARELLI: We're tracking civilian suicides, family members. This year we've had a total of 10 as opposed to last we had 12. I think most of you know because the CDC tracks suicides on a calendar year, we use a calendar year, which confuses some people, when we track suicides. So our numbers are calendar year numbers, not to the normal government fiscal year numbers. And this year we've had 10. Last year we had 12. We also track VA civilians. And this year we've had a total of 22 and last year we had a total of 26 for year.

MS. KEMP: I think one of the things the report calls for is this strong partnership between the DOD and the VA and the Department of Health and Human Services. And the Department of Health and Human Services has taken on somewhat of the cause of family tracking. And I think we need to work closer together.

GEN. CHIARELLI: But I just would remind everybody – I can't make a family member report a suicide or even attempted suicide. That's one thing that lies outside of our ability, even in the military to do. So I look with suspect at even the numbers that I'm collecting.

Q: So that – (off microphone) – campaign that's working so well within the Army I think needs to be expanded to family members because we have a different kind of stigma but it's just as prevalent, particularly among officers and NCO wives. And we have to get our messaging that actually translates in the system.

MS. KAYYEM: Oh, microphone.

Q: Sorry. I'm done.

MS. KAYYEM: Okay. Thank you. Steve, I believe.

Q: I'd like to thank you for the report. It's going to spark a lot of conversation.

Meg, this question is for you. Military leaders must eliminate stigma. And eliminating stigmas include a multi-pronged approach which must include accountability. On page 10 of the report, you said that military leaders must be held accountable. So my question is what do you think accountability is?

And I'd like to ask the same question to General Chiarelli. What's accountability? And how many leaders in all of the investigations you've conducted have been held accountable, or what changes have you made to train them, or perhaps – you know, in the military that I served in, if you did something wrong, it was reflected in your OER, your NCOER.

MS. KAYYEM: Do you want to begin?

MS. HARRELL: I will. Thank you. We do think that leaders need to continue to address stigma. That may be the hardest challenge of this report and it's something that leaders at all levels in the military have taken on. I don't think anybody would say that we've reached success yet. It's something that needs to continue. Again, it may be the toughest thing there.

As far as accountability, I'd like to underscore that this policy brief wasn't about pointing fingers or assigning blame. The real point here of this policy brief, our intent, is that things need to be done as move forward to try to address this.

MS. KAYYEM: General?

GEN. CHIARELLI: We've got to go back and take a look at some of the laws and policies we've put in place that make it very, very difficult for military members or anybody else.

One of them is that we used to, because of the stigma associated with seeing behavioral health folks, there is a very complicated and legalistic way that if I want to command, direct somebody to behavioral health, that I have to do it. And if I violate that – and as the vice chief of staff of the Army, I have had cases come in front of me that I've had to adjudicate where the individual has done exactly the right thing in ensuring that somebody got to a behavioral health professional but in doing so did not follow current policy that requires certain things be done lockstep before you're allowed to do that. And I have had to take action on those cases. The action I've taken is to call them into my officer for counseling where I tell them, thank you very much for what you did.

But we've got to change those kinds of things so that we can get into the 20th century and understanding that behavioral health issues and injuries are real no kidding injuries. And that's what we I think as a society have failed to do. And I hope the military can help lead an effort to do that.

MS. KAYYEM: I'm going to take – and then I'll head over here.

Q: This question is for you, General Chiarelli. You talked about the after action review that you do after each suicide. And I'm wondering if you could talk a little bit more about that process, and is that standardized across all the services?

GEN. CHIARELLI: I can't speak for the other services. I can tell you a death in the United States Army starts with what we call a 36-liner. It's a – we're big into reports. It's probably 10 lines more than it needs to be but it's 36 lines. And in that we go through everything from the prescriptions an individual was on, how many times they've seen a behavioral health specialist. This is all privileged material that comes to us. And once the medical examiner – not until the medical examiner has indicated, yes, this was a suicide do we hold what's called this SRG and discuss each case with the commander, who in fact talks about the individual case – what went right and what went wrong. And it's always what went wrong and what they could have done about it. And it's just an open discussion to try to pass lessons learned to all other commanders who are up listening to this.

I talk to folks in Afghanistan and Iraq. No one is immune from having to be up to talk these. If they've got cases, they've got to talk and brief it to the vice chief of staff of the Army every single month. And we're trying to learn from those. And they have proven to be very beneficial and pointing at some of the policy issues we've got.

I just recently – we just recently published a policy, and I think the report correctly points out, I am not allowed to ask a soldier who lives off post whether that soldiers have privately owned weapons. I have to go through a very distinct process, the commander does before he can ask those questions for a soldier who lives off post. And when you have somebody who is moderate to high risk and seeing a behavioral health specialist, the studies that I have read indicate that when you can separate the individual from the weapon, because suicide is in most instances a spontaneous event, often accompanied with alcohol or prescription drug abuse, when you can do that, you can lower the incidence of suicide. And we have issues in even being able to do that.

MS. KAYYEM: We have lots of questions. So you. Yes, sir.

Q: Thank you. Chaplain Johnson, Army Reserve, sir. I think I would like to hear you speak about the real success and how we intervene with those who actually do come up and declare themselves as suicidal, having some kind of suicidal ideation.

I will also – because I'm a Reservist, 28 days a month I'm wearing civilian clothes and working back in the Philadelphia area and part of that is with the local Suicide Prevention Task Force in our county. And there is not – despite of all the mental health resources available, there is not within the general population the kind of attention to and training that people can identify and respond to someone who is suicidal.

So my whole point, sir – and I would like to hear you speak to the successes, which is those who come up on the radar we deal very effectively with them.

GEN. CHIARELLI: We do. And some of those are the most difficult cases. There's many times where soldiers exactly what they're supposed to do, chains of command do what they're supposed to do and follow exactly the way you would want them to do that.

But if a person wants to commit suicide, it is very, very difficult to stop them ultimately from doing that. It really is. You can get them the help. You can do so much, and we have many, many success story at being able to help them. And I will tell you, the VA's line is one of the – it is truly a great national resource in being able to get to someone who can help you over the phone and they do a fantastic job. But there are all kinds of success stories out there where soldiers have intervened, got a solider to help and got them past the immediate

crisis. But we are concentrating, quite frankly, on those where we don't have success and trying our darndest to figure out how we can fix that.

MS. KEMP: There are few – and I have to interrupt here.

MS. KAYYEM: Go ahead. Thank you, Dr. Kemp.

MS. KEMP: There are a few interventions that I think both the DOD and the VA have found to be effective in the immediate need arena. And I think that everyone in America should know what those are.

And one of those you alluded to and that's removing the weapon from the person's home. At that point, when someone is in danger, temporarily making it difficult for them to seek any means from which to hurt themselves is effective. There's a stalling technique involved.

There are studies that say if someone planned to jump off a bridge and the bridge is closed, they won't necessarily walk to another bridge. They'll think about it. If they go to get their gun and the gun has a gun lock on it or it's not in their home, there's a stalling technique. And I think that that in itself is the single most effective thing that we can do as a society to help anyone who we think is in danger of taking their life.

I think the other thing that we've learned overtime is that making sure people know that help is available, that they have a number to call, they have something in their pocket they can pull out and use, and that we as a society aren't afraid to ask the question: are you thinking about hurting yourself? Are you thinking about killing yourself? I don't want you to do that. I care about you. Can I help you get help? And that's just my public service announcement for today.

MS. KAYYEM: Dr. Kemp, the report say that 48 percent of military suicides occurred with privately owned weapons. And before this panel, we were talking about some of the surprising findings at least for veterans. Could you explain to the audience what are some of those as relates to handguns, some of the trends?

MS. KEMP: One of the things that we worry about in the veteran population is that veterans are at a higher risk than non-veterans to die by suicide. The numbers vary depending on what states data you're looking at and who did the study and how they

controlled for age and gender. But what it boils down to that the rate for veterans in general is slightly higher than it is for the general population. Within that there's deeper concerns.

And one of the concerns is that women veterans are at a higher rate than non-veteran women to die by suicide, which is concerning, because in the national numbers we know that women, while they may be more likely to attempt suicide, are much less likely to die by suicide overall. So the fact that we have this group of women veterans who may be changing that dynamic for themselves is worrisome. One of the reasons we worry about that is that they are more likely to use firearms as an attempt method. We know that firearms are a more lethal and the chances of dying are higher if they try to kill themselves using a gun. So I think those are things to be aware of.

MS. KAYYEM: Okay. The gentleman here.

Q: Good afternoon. Tom Berger with Vietnam Veterans of America. And thank you for putting on this briefing this afternoon.

With all due respect, Dr. Harrell, I want to return to my colleague Steve Robinson's question and perhaps not using the term leadership, which is only mentioned one time in the report. Let's call it command structure.

When we look at the reports from the RAND Corporation that came out earlier this year, both on resiliency programs, as well as on suicide risk prevention programs, leadership, let's call it, command structure, was mentioned very specifically in both of those reports, okay, as reasons why in the case of resiliency programs they've been failing in the military. So I wish that the general would please comment.

GEN. CHIARELLI: About leadership?

Q: About leadership's role or command structure's leadership.

GEN. CHIARELLI: Well, I think one of our most effective programs and I think of one of the programs that's going to be the most effectives is one that we've rolled out called Comprehensive Soldier Fitness. We have an online test called a GAT that measures resiliency.

Now, it's evidence based – most people believe it's evidence-based. There are always some of those who don't because when you get 15 psychologists in a room and ask them an answer to a question, you're going to get 15 different answers, I promise you. But we have the GAT.

The GAT measures resiliency. And once you take the GAT, the GAT recommends a series of modules that are online that a person could take, again, in order to reduce the stigma and make this something that the solider goes to, we require to take the GAT but we don't monitor the progress and how they work on increasing their resiliency.

We have also have master resilience trainers that we're rolling out to each one of our battalions now who will go along with the unit leadership and help teach resiliency techniques to soldiers, because we really believe that if we want to get to the left of the event, we have got to increase the amount of resiliency our individual soldiers have.

Q: There's a follow-up, general.

MS. KAYYEM: You need the microphone. A quick follow up. You're going to just need the microphone.

Q: As a follow-up, as you recall, one of the criticisms in the RAND report on the resiliency studies was that there were no evaluations done. So how are you evaluating this program you just talked about in a meaningful sense?

GEN. CHIARELLI: Well, one of the things we're doing is we've entered into a $50 million study with the National Institute of Mental Health, the first ever end-to-end look at suicide in this entire country. It is being framed after the very famous Framingham report to reduce the incidence of cardiac death in this country by over 66 percent today.

Now, this is a five-year study that I think will go longer. And what we are trying to do is to come up with an algorithm, not that says Chiarelli is going to commit suicide at age 29, but an algorithm that is much the same as when you and I go to the doctor and they ask you, do you have any family history of heart problems? You take an aspirin every day? What's your blood pressure? What's your cholesterol? All those came out of Framingham. We think, and the National Institute of Mental Health thinks, that they're going to be able to do the same for us when it comes to behavioral health and these issues.

And this study I think is going to be groundbreaking, not only for the military, what comes of it. We're right now in the middle of an all-soldier study and a survey and an all-Army survey to gather this data. We're going to be able to track this along with how soldiers score on the GAT. And we're going to be able to draw some conclusions to exactly what is the impact of resiliency and low resiliency on suicide. I really feel that within two to three years you're going to see things coming out of this study that are going to have a huge impact across all of society.

MS. KAYYEM: I have a question up here. Thank you.

Q: My name is Lyn McCall. I'm retired. General Chiarelli, you mentioned that we're close to having a biomarker for our post-concussive events.

GEN. CHIARELLI: Yes, sir. Concussions. Yes, sir.

Q: Is there a link between concussive events and the propensity for suicides?

GEN. CHIARELLI: What we know is that there is – if you look at the work of Dr. Ann McKee up in Boston that she's doing on the Tau protein, if you're one of the believers, like I am, in her work, it indicates the Tau protein, a very important protein in the binding of the neurological system, it seems to with excessive blows to the head mutate. I'm not a doctor. I'm a tanker. But what was explained to me, it bends over itself. It comes up, it collects in the brain, and it has the effect of beginning to eat away at the brain.

You all heard – I think he's named Dave Duerson, the Chicago Bears football player who committed suicide here not too recently really in a different way than most men do. Most men put a bullet through the head. He put it through the chest. He put it through his chest because he wanted Ann McKee to do the biopsy of his brain because he had a very successful NLF career, very successful in business, and then he started to display all the symptoms: early dementia, problems getting along with people, anger management issues. He killed himself. They looked at his brain and he had the same buildup of Tau protein she's seen in just about every single case she's looked at the NFL. And it's also been studied in boxers. So that's the kind of research I think we need.

And the really exciting thing about this research – I just have to say this – is there's many people who believe that this will help us with the problem of dementia because there's a belief that the same kind of – by some, and it's research, it's not finished yet – that the same kind of buildup of Tau protein could be one of the reasons why people develop dementia in later life.

MS. KAYYEM: Dr. Harrell.

MS. HARRELL: Consistent with that there is research that shows that veterans that have traumatic brain injury, TBI, are about 1.5 times as likely to die by suicide.

MS. KAYYEM: Can I just – I know there's a lot of questions, but just the issue we haven't discussed – we talked about the length of 10 years of war so to speak. In the findings that all of you are dealing with, is it something unique about these wars and multiple deployments where we haven't talked about Iraq or Afghanistan specifically, whether it's comparative to previous wars or if in the findings about veterans is this different than what the veterans are – from Vietnam or First Gulf War in the data, if we could just talk about that, those wars specifically.

MS. KEMP: I think we've alluded to some of the difficulties in determining that. And that is our tracking of veteran suicide, and actually suicide in the military and in the general population in the early years. So we don't have good comparison numbers to go back and to look at.

And the information I have and what informs me actually is information about veterans who get care within the VA system because they're the ones that I can track and I can follow.

I know now that our numbers are somewhat bimodal. When we look over the life spectrum, we have an increase of suicides in people who are in or under 35 age group and then we have another peak that corresponds with national suicide numbers for people in middle age or just past middle age, which actually is probably our Vietnam era veterans. So there's still two groups of people within the VA that we're concerned about. I think over time we'll find out what happens to this early group as they age and they're out of the military for longer.

But I think that one of the things that we need to remember is that veterans are people too and so they're all also subject to all of the stresses and normal lifespan changes in suicide rates. And imposing that on top of their veteran experience is something we haven't quite figured out how it makes a difference.

What I do know is that the way we are dealing with and working with our newer veterans is different than the way we dealt with our Vietnam veterans when they came back. We hope we've learned lessons. We're doing things differently. We hope we're doing them better. And I think that perhaps that this is a positive outcome is the fact we're even having this discussion in a public forum with a room full of people speaks to the differences in both of our agencies' perceptions.

MS. KAYYEM: Anyone else?

MS. HARRELL: Can I say a couple of words about the link between deployment and suicide? It's always seemed obvious and intuitive that these things should be linked, but until this past summer, the prevailing wisdom was actually that data didn't support that link at all.

And now, as of some analysis done this past summer, what we're seeing is that there's a link for the Army but it varies for the other services. Even before we saw this link, clearly we still knew the tie between TBI and PTSD and suicide for those service members that come back from theater with those types of wounds. They were at risk. What we now see in Army data is that those who deployed were about one in a quarter times more likely to die by suicide than those who did not deploy at all.

But that's – we don't see that in the other services. And the extreme of that is in the Air Force. The Air Force will tell you that those who do not deploy, have never deployed, are three and a half times as likely to die by suicide as those who have deployed three times, exactly the opposite relationship. It's a complicated relationship.

MS. KEMP: And we don't know what happens overtime to those people at all.

MS. HARRELL: We don't know.

GEN. CHIARELLI: I could throw out factoid after factoid, but be very careful about numbers. You'll see reports all the time about individual posts, camps or stations. The very first think you should ask is what is the rate of suicide at that post, camp or station?

The number of suicides at Fort Hood is naturally going to be higher when there's 40,000 soldiers there than there's going to be when there's 12,000 soldiers there because they're all deployed. And we follow reports of increased suicides at locations, and normally it's because the increase is based on people coming back home in a post being full of soldiers as opposed to when they were all deployed.

The most likely person to commit suicide in the United States Army is a 29-year-old private. That's what we found when we did the "Red Book." Now you ask yourself why. And I would argue that if you join the Army at 29-years-old, one or two things happen. You've either got real shot at patriotism and decided to go down one night and sign up, or you're going through some life experiences that you are reaching out for a life saver. And what we find with these kinds is that their spouse either left them, they were left with two kids. They have no medical insurance or health insurance. We bring them into the Army, we put them through six months of training, they think that they've finally made it, they go to their first post, camp and station, and four months later they're looking for somebody to take care of their kids because they've got to go down range.

So one things we've told our leaders is when you get these kids who come in at a later age, those are kids that are probably a higher risk category. You need to take a little bit more time interviewing them and talking to them about what the condition of their life is.

MS. KAYYEM: This is also on the webinar so I think we have questions from Twitter. Is that true? Yes.

Q: I have a question from Twitter for the entire panel. What can the American public do to help reduce suicide in the military?

MS. KAYYEM: It's a great question. What can the American public do to reduce suicide in the military? So I'll just go down the panel – or veterans.

MS. KEMP: I'll start. I think awareness and support. This is an American public. It truly is a VA problem. It's a Department of Defense problem but it's an American problem. And

the suicides in the military affect all aspects of American life. So we've heard families are hugely impacted. Children are impacted for generations to come.

I think being aware that people have needs and that our military service men and women and veterans need to talk about their experiences, but they need practical assistance too. They need jobs. They need support. They need friends. They need community involvement, and being there for people and each other is probably the single most positive thing we can do.

MS. KAYYEM: General.

GEN. CHIARELLI: I would argue pretty simply, help us eliminate the stigma, not only the stigma in the Army but the stigma in what I term is civilian life. That is really what needs to happen. We need standards that are applied across the board so we really understand the breadth of the problem.

I would hope that we could get a little quicker in reporting the statistics. I think it's really – is a problem like this. You know, there's 30,000 to 35,000 folks in the country that commit suicide every single year. It's going to be somewhere in that number. And we need those statistics. We need to track those statistics so we can start to get at this issue and end as much as we possibly can the incidence of suicide.

MS. KAYYEM: Meg.

MS. HARRELL: General, it's a pleasure to say I agree with you on that. It's the stigma and the data. (Laughter.)

MS. KAYYEM: Further questions. In the back, right there. Yes, you. And then I'll head to you. Okay.

Q: General Chiarelli, your comments about the 29-year-old privates notwithstanding, I believe you said finding those or identifying those at risk is the hardest task. Assuming you could do that, assuming you could find those cohorts of people who for various different reasons or combination of reasons were at highest risk to commit suicide, given the policies and the procedures and the constraints that you have to follow, what do you think you could do that would impact the incidence?

GEN. CHIARELLI: I mean, one of the things we've tried to do – I'll give you an example of some of the things we tried to do. We tried to change our own regulations. It used to be when an individual reported to an alcohol abuse center to get help, that it was automatically reported to his chain of command.

We started a pilot at six locations where that's not the case, where an individual self-refers himself for what we call the ASAP program, Army Substance Abuse Program. We do no report it to the chain of command. We leave those centers open late at night so people can seek the help that they need and on weekends so they can seek the help that they need. That program was initially rejected by commanders but in each instance where we were able to do it, we have had tremendous success at bringing in a portion of the population that's high risk, that doesn't want to admit they're high risk because they don't want to be branded as an abuser of alcohol.

The problem I have in rolling that out throughout the entire United States Army is the national problem. It's a problem with health care. We just do not have enough behavioral health care folks. And someone who is an Army substance abuse counselor has the ability over time to gain the experience they need to move up, to become a behavioral health care specialist who makes more money, and I have this problem of trying to fill up the number of ASAP counselors – that's what I call them – to get at this issue. I don't want somebody to self-refer themselves for alcohol abuse and say, come back five weeks later when we can see you. I want to make sure that we can provide them immediate help when they do that.

It's those kinds of things I really think we have to look at. I think we have to make maximum use of tele-behavioral health. And one of the problems with tele-behavioral health is getting all doctors to believe in tele-behavioral health.

You know, this group of population, the youngsters of today, there's nothing they like better than communicating over some of the things that those of us who are a little bit older might not like to do. And what we found when we've rolled out these pilot programs in doing this is that a kid who gets on Skype and talks to a doctor is much more forthcoming on talking about his or her problems than they would be if they're sitting across from you and me.

But this is one way we can make use of assets when I have brigades return home so that rather than use the PDHA, you know, the post-deployment health assessment, that we give

every single soldier, starting with the brigade commander and brigade commander sergeant major a 20 to 30-minute evaluation to see if they're going to have a problem reintegrating into their community.

MS. KAYYEM: I promised. Yes, right there.

Q: Nancy Sherman, Woodrow Wilson Center and Georgetown University. This really follows on your remarks, general, and that has to do with the art of being a clinician. There's science. There's anti-stigma. Your statistic was alarming that 50 of the suicides or so had been in behavioral care. So resources aside, is there – and standardization aside, is there concern about what this so-called art of building rapport and getting people to trust you, which is what clinicians do, are supposed to do, whether be through Skype or phone calls or consults, one-to-one consultations, is that something that the Army is looking at and recommendations regarding that?

GEN. CHIARELLI: We're looking real hard at it. I've spoken about this a lot. I mean, I wish – we used to – in this country, we used to make sure of boards that were doctors when they got together would sit around and talk. If somebody's lost on the operating table, they would sit and talk about the operation, what happened, what went right and what possibly went wrong. My understanding – and, again, I'm a tanker, not a doctor – is many of those boards have gone by the wayside because of the fear of individuals being sued and malpractice insurance.

One of the things that we have in the military that's a blessing is you can't do that. And I have been working very, very hard to get my clinicians in high-risk, or what they thought were medium-risk cases, where things go bad to get together and talk about lessons learned, about what they possibly could have missed that would have caused them to put that person in a high-risk category and made them an inpatient rather than an outpatient. But it is difficult to do that even in a hierarchical organization and with four stars on your collar across the force. But I think we're starting to make some progress.

MS. KAYYEM: I have a – please, both of you.

MS. KEMP: Yes. A comment there. I think one of the things we tend to forget is we're well aware that the new generation likes to communicate over electronic mediums. We've had almost 30,000 chatters into our chat space to talk about suicidal issues.

One of the things we don't remember is that we have a whole new generation of medical professionals now coming out of academic institutions who are psychologists, psychiatrists, social workers, who are going to be providing mental health care to not only the new generation, but generations that are already available. They too prefer to communicate over different mediums than we're used to.

So I think it really behooves our academic institutions now to take that into consideration when they teach people and prepare people to provide mental health care, not only in the future but right now.

We know that in medical institutions across the board suicide is not a topic that even today is discussed or talked about or people taught from an internal medicine or primary care perspective how to work with suicidal patients or to ask the questions. And so I think it behooves us all in our institutions to do a lot of clinical training and support for all sorts of reasons, medium only being one of them.

MS. KAYYEM: Did you want to add something?

MS. HARRELL: No.

MS. KAYYEM: I have one more – the woman on the side here, if you could stand. And just to let you know, I have like about 30 people and no minutes so I think we'll be able to discuss after, but my apologies. And this has been an interested audience so that's good.

Q: Hi. C.J. Jordan, Steptoe Group, tagline – "You must know me to treat me." General Chiarelli, can you talk about some of the things you instituted dealing with prescriptions? I mean, that's part of the report when we talk about abuse.

GEN. CHIARELLI: Prescriptions.

Q: The prescription drugs.

GEN. CHIARELLI: Oh, prescriptions. Well, you know, I totally agree with the report. I wish we had open season to collect drugs that people aren't using. One of the things that we had to do was close open prescriptions.

You know, the person who goes in and gets wisdom teeth pulled and has an open prescription for Percocet. We've in the Army gone back and closed those. We've seen a – we're working very, very hard to reduce the reliance on psychotropic drugs. At Walter Reed alone we went from 83 percent of our soldiers in our WTU were on kind of psychotropic drug down to 8.5 percent.

But one of the reasons why we saw an increase, and I saw it when I went out to talk to soldiers, when I visited six installations in seven days, and I would talk to soldiers, they would say, you know, I go see the behavioral health specialist and what does he do? Asks me three questions and throws me a bag of drugs. Well, why did that happen? They're not bad people. But the fact of the matter is there's 15 other people lined up to see this person and they take – hey, "maybe this will work" route, this works in some cases. And we were throwing and dispensing out too many drugs. That's got to end. We are working very, very hard on alternative pain methods and trying to get at this whole issue.

But there are all kinds of policies and laws out there that make it difficult for us when we want to, to try to pull that back, and I think the report clearly points out. I wish it was easier to do that. We've got a request in that will allow us to collect those drugs, but we'll see if it gets approved.

MS. KAYYEM: Thank you. Did you want to add on the recommendation?

MS. HARRELL: I think the report speaks to that one.

MS. KAYYEM: Oh, okay. We are going to close this event but certainly not the discussion and nor the report. I wanted to give everyone an opportunity, quick opportunity if any final comments or statements about the report and this issue. Dr. Kemp.

MS. KEMP: I want to thank you for the report. I think it is important to keep remembering that that issue is not going away. My other plea is to remember that veterans aren't going away and that this is going to be a problem that we will deal with over many years to come. It's not going to go away when the wars are over and the conflicts are over, that veterans will still need our help and support.

MS. KAYYEM: General.

GEN. CHIARELLI: I want to thank you for the report, as difficult as I can be on this subject. Anything that would pull this group of people together to talk about this, to webcast it around the country is something we should all be thankful for. It's a complicated subject. You've done a good job at trying to lay out some of the issues. I would just make that plea to people to help us end the stigma associated with folks getting the help that they need for behavioral health issues.

MS. HARRELL: I'd like to thank my panelists and thank everyone for coming and for listening online. This is a tough issue. We've laid out recommendations that we felt were actionable but in no way did we mean to imply that any of them were easy. This is something that's going to take continuing work. And Dr. Kemp is absolutely right. Veterans are in the public eye right now. As these wars phase down and our militaries downsize, we'll have more veterans out there and they will be less in the public eye.

MS. KAYYEM: I want to thank all of you. Thanks, CNAS. And I also thank the audience for coming and your questions. To end with something Dr. Kemp said, this is an American problem and your energy and interest in this subject is something that we welcome. And thank you very much.

(Applause.)

(END)